

Statement of

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before the

House Committee on Homeland Security
Subcommittee on Prevention of Nuclear and Biological Attack
Subcommittee on Emergency Preparedness, Science, and Technology
U.S. House of Representatives

Hearing on

"Protecting the Homeland: Fighting Pandemic Flu From the Front
Lines"

Presented
February 8, 2006

Introduction

Mr. Chairmen and members of the subcommittees, I want to thank you for allowing me to testify today on behalf of the American College of Emergency Physicians at this joint hearing entitled, "Protecting the Homeland: Fighting Pandemic Flu From the Front Lines."

ACEP is the largest specialty organization in emergency medicine, with over 23,000 members who are committed to improving the quality of emergency care through continuing education, research, and public education. ACEP has 53 chapters representing each state, as well as Puerto Rico and the District of Columbia, and a Government Services Chapter representing emergency physicians employed by military branches and other government agencies.

Emergency departments act as our nation's health care safety net. Unlike any other health care provider, the emergency department is open for all patients who seek care, 24 hours a day, 7 days a week, 365 days a year. We provide care to anyone who comes through our doors, regardless of their ability to pay. At the same time, when factors force an emergency department to close, it is closed to everyone and the community is denied a vital resource.

As the frontline of emergency care in this country, emergency physicians are particularly sensitive to the devastating impact an avian flu pandemic would have on our patients and our communities. To put this in perspective, I would like to share with you the findings of the Centers for Disease Control and Prevention:

"In the absence of any control measures (vaccination or drugs), it has been estimated that in the United States a 'medium-level' pandemic could cause 89,000 to 207,000 deaths, 314,000 to 734,000 hospitalizations, 18 to 24 million outpatient visits, and another 20 to 47 million people being sick. Between 15% and 35% of the U.S. population could be affected by an influenza pandemic, and the economic impact could range between \$71.3 and \$166.5 billion."¹

As this statement indicates, if the avian flu pandemic, which has been the focus of world attention over the past several months, should begin spreading from human to human and then reach our shores, the consequences to the United States would be catastrophic. What makes a potential avian influenza pandemic so deadly is that, like some biologic agents, it would be transmissible from person to person and could spread rapidly in an urban environment or through mass transportation. Optimally, treatment must be initiated as quickly as possible, although contracting avian flu would not result in obvious characteristics that would distinguish it from the normal flu initially. Therefore, detecting it, even when symptoms occur may be difficult.

The state of readiness in our nation's emergency departments and the ramifications of patients who have been infected with the avian flu virus appearing at hospital emergency departments around the country are what I will explore in my testimony today.

¹ Centers for Disease Control and Prevention. January 17, 2006 "Pandemic Flu: Key Facts"

Patient X

Let me give you an example of what could be a typical avian influenza outbreak scenario. Patient X unknowingly contracts the avian flu while on a business trip in Europe immediately prior to boarding a plane for Atlanta. Not only will this person infect the passengers of this plane and anyone else who comes into contact with this individual at one of the busiest airports in the world, but the passengers who have final destinations outside Atlanta will also carry the infection to other passengers, and so on, as the disease begins to spread exponentially. Of course, it will take several days for this person to feel sick enough that they go to their local emergency department.

This infected patient now sits in a typically overcrowded emergency department spreading the infection to everyone else in the waiting room and they, in turn, will either eventually be admitted to the hospital or treated and released to go home and spread the infection to their family and neighbors. Even once they are admitted to the hospital, the majority of patients still remain in the emergency department (also known as "boarding" a patient in the emergency department) waiting for an inpatient bed for more than four hours, with nearly 20 percent of those patients waiting in the emergency department for more than eight hours², which would continue to expose these infected individuals to other emergency department patients, as well as patients throughout the hospital due to the high-volume of air recirculation.

While it is common practice to ensure a patient who enters the emergency department with a cough or fever wears a mask while waiting to be treated, it may take over an hour before a triage nurse has an opportunity to see that individual if the emergency department just received multiple ambulances and the waiting room is already saturated. In addition, the patient may require oxygen treatment and a nebulizer, making the use of a mask irrelevant, and it was the use of nebulizers that caused SARS to spread so rapidly through emergency rooms in 2003.

Without sufficient warning, emergency physicians and nurses would be unprepared to place arriving avian flu patients in isolation until it was too late. Since most hospitals only have one isolation unit, there would be no way to isolate the next patient infected with avian flu. By this time, the emergency physicians and nurses have also been in contact with avian flu and, unless they have been previously inoculated, would be at high-risk of contracting the disease themselves, potentially diminishing their ability to provide care for incoming patients.

Overcrowding and Lack of Surge Capacity

As the disease begins to spread rapidly among the population, the strain will cripple America's 4,000 hospital emergency departments as the majority of the nation's emergency departments are already operating either at or over critical capacity. Emergency department visits rose more than 26 percent in a decade – from 89.8 million in 1992 to 114 million in 2003. At the same time, the

² General Accounting Office. GAO-03-460. March, 2003 "Hospital Emergency Departments: Crowded Conditions Vary among Hospitals and Communities."

number of emergency departments decreased by 14 percent.³ In addition, between 1990 and 1999, hospitals lost 103,000 staffed, inpatient medical/surgical beds and 7,800 Intensive Care Unit (ICU) beds.⁴ As a result, fewer beds are available for admissions from the emergency department. Once the emergency departments have filled all of their beds, there is no reasonable way to expect that these stressed systems will be able to suddenly create the surge capacity necessary to effectively manage a pandemic, natural disaster, terrorist attack or other mass-casualty event.

When crowding becomes so severe that patient safety could be jeopardized, ambulances must be diverted to other hospitals, potentially causing precious time to be lost. In 2001, two-thirds of emergency departments diverted ambulances to other hospitals. Because overcrowding is most severe in areas with large populations (where the potential spread of infectious disease poses the greatest risk), nearly one in 10 hospitals reported being on ambulance diversion 20 percent of the time (more than four hours per day).⁵

Need for Effective Syndromic Surveillance

Knowing about an avian flu outbreak elsewhere in the world or here in the United States could significantly improve preparations and reduce diagnosis time. For this reason, it is essential that our nation have a real-time syndromic surveillance system linking emergency departments across regions with state public health departments and nationally with the Centers for Disease Control and Prevention to serve as an early warning system for epidemics. Existing data collection systems are currently limited in their capacity and ability to provide information to health authorities and the public. Until such time that we do have an effective means of data collection and dissemination, emergency physicians and nurses will serve as critical components of the nation's human syndromic surveillance system.

³ Centers for Disease Control and Prevention Advance Data from Vital and Health Statistics "National Hospital Ambulatory Medical Care Survey: 2003 Emergency Department Summary." No 358. May 26, 2005.

⁴ "Emergency Departments: An Essential Access Point to Care," *AHA Trendwatch* 3, no. 1 (2001): 1–8.

⁵ General Accounting Office. GAO-03-460. March, 2003 "Hospital Emergency Departments: Crowded Conditions Vary among Hospitals and Communities."

Planning and Preparedness

Detection of a disaster, act of terrorism or epidemic will only be effective if appropriate preparations have been made at all levels of government and the private sector. In most disasters, the emergency department is the frontline. History has shown that during a disaster, such as 9/11 or the anthrax scare here in the nation's capital, nearly 80% of patients simply go to the nearest emergency department, bypassing ambulance transport. In fact, only a small percentage of patients are actually managed by EMS. Emergency department personnel are the forgotten first line of response in disasters.

Since 9/11 we have appropriately spent billions on preparedness. But emergency departments have received virtually none of that support. Policymakers and the public have assumed that the nation's emergency departments will be able to meet their vital safety net function. However, lack of overall capacity may lead to a breakdown of the health care safety net when we need it most. If we are unable to effectively respond to a disaster or pandemic, people will suffer needlessly and some will die.

The private sector also will play an important role before and during an avian flu pandemic. In addition to providing goods and services to the public and medical personnel, workplace policies that diminish the potential spread of infectious diseases are critical. Establishing an ethic of infection control in the workplace that includes options for working offsite while ill, systems to reduce infection transmission and worker education are vital.

ACEP Recommendations

We must take steps now to avoid a catastrophic failure of our medical infrastructure and we must take steps now to create capacity, alleviate overcrowding and improve surge capacity in our nation's emergency departments.

My colleagues and I at the American College of Emergency Physicians present this 10-point plan to achieve these goals and we urge Congress to enact these measures in order to effectively manage a pandemic, natural disaster, terrorist attack or other mass-casualty event.

1. We must increase the surge capacity of our nation's emergency departments by ending the practice of "boarding" admitted patients in emergency departments because no inpatient beds are available. This will require changing the way hospitals are funded to allow for inpatient and intensive care unit surge capacity to manage this burden.
2. We must implement protocols to collect and monitor real-time data for syndromic surveillance, hospital inpatient and emergency department capacities and ambulance diversion status. Collection of this data is vital to developing appropriate protocols.
3. Homeland Security agencies on the Federal, State, and Local levels need to understand that hospitals and Emergency Departments are part of the community's Critical Infrastructure. We can not have response and recovery in a disaster without fully functioning, protected, and connected health resources.

4. We must require hospitals and communities that are severely affected by a natural or man-made disaster, or even a severe influenza outbreak, to postpone elective admissions until the crisis has abated. We must develop a way to compensate those facilities for their loss of revenue.
5. Command and control of disaster medical response must be more coordinated across federal, state and local agencies and departments.
6. We must establish a committee of stakeholders and disaster medicine experts from the public- and private-sectors and academic institutions to develop and/or refine national medical preparedness priorities and standards. We must change the national preparedness culture to one which is consensus-driven and evidence-based.
7. We must provide federal and state funding to compensate hospitals and emergency departments for the unreimbursed cost of meeting their critical public health and safety-net roles to ensure these emergency departments remain open and available to provide care in their communities.
8. We must establish a sustainable funding mechanism for disaster preparedness for hospitals, emergency departments and emergency management that is tied to national benchmarks and deliverables.
9. To ensure emergency physicians and nurses play a primary role in disaster planning and are considered in any national allocation of resources and protective measures, Congress should continue to include them in any definitions regarding first responders to disasters, acts of terrorism and epidemics.
10. Congress should pass H.R. 3875, the "Access to Emergency Medical Services Act," which provides incentives to hospitals to reduce overcrowding and provides reimbursement and liability protection for EMTALA-related care.

Conclusion

While adopting crisis measures to increase emergency department capacity may provide a short-term solution to a surge of patients suffering from the flu, ultimately we need long-term answers. The federal government must take measures necessary to strengthen our resources and prevent more emergency departments from being permanently closed. In the last ten years, the number and age of Americans has increased significantly. During that same time, while visits to the emergency department have risen by tens of millions, the number of emergency departments and staffed inpatient hospital beds in the nation has decreased substantially.⁶ This trend is simply not prudent public policy, nor is it in the best interest of the American public.

Let me close by assuring you that in any local, regional or national disaster or epidemic, the nation's emergency physicians and emergency nurses will be there to do their jobs, as was evident during Hurricane Katrina. If the avian flu pandemic were to spread throughout America before appropriate safety measures could be implemented, then it's reasonable to expect a 20% loss of emergency department personnel due to death or disability. America's emergency departments are already operating at or over capacity. This loss of emergency department

⁶ Centers for Disease Control and Prevention Advance Data from Vital and Health Statistics "National Hospital Ambulatory Medical Care Survey: 2003 Emergency Department Summary." No 358. May 26, 2005.
"Emergency Departments: An Essential Access Point to Care," *AHA Trendwatch* 3, no. 1 (2001): 1–8

personnel is unsustainable and would cripple this nation's health care safety net and the quality of patient care would be severely jeopardized.

Every day we save lives across America. Please give us the capacity and the tools we need to be there for you when you need us... today, tomorrow and when the next major disaster strikes the citizens of this great country.